IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 3020 0001 4044 7441

March 22, 2013

Pascale Snodgrass, Administrator
St Alphonsus Transitional Rehabilitation Unit
1055 North Curtis Road
Boise, ID 83706

Provider #: 135119

Dear Ms. Snodgrass:

On **March 8, 2013**, a Recertification and State Licensure survey was conducted at St Alphonsus Transitional Rehabilitation Unit by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance**. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should

sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 4, 2013**. Failure to submit an acceptable PoC by **April 4, 2013**, may result in the imposition of civil monetary penalties by **April 24, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

  a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.

  b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

  c. Start date of the audits;

- Include dates when corrective action will be completed in column 5.

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **April 12, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 12, 2013**. A change in the seriousness of the deficiencies on **April 12, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 12, 2013** includes the following:

Denial of payment for new admissions effective **June 8, 2013**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 8, 2013**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 8, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **April 4, 2013**. If your request for informal dispute resolution is received after **April 4, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135119	A. BUILDING _____ B. WING _____	03/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS TRU	1055 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Lorraine Hutton, RN, Team Coordinator Jim Troutfetter, MEd, QMRP Michael Case, BSW, LSW, QMRP Monica Nielsen, MEd, QMRP Trish O'Hara, RN Survey Definitions: ADL = Activity of Daily Living BIMS = Brief Interview for Mental Status MDS = Minimum Data Set VRE = Vancomycin Resistant Entercoccus Infection	F 000	RECEIVED APR 05 2013 FACILITY STANDARDS	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225	F 225 *1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* **Resident #10 no longer resides in the facility.** **Resident #9 no longer resides in the facility.** *2.) How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?* **Review of current Incident Reports – completed on April 2, 2013.**	4/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pascale Snodgrass | TITLE: DON | (X6) DATE: 4/5/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not provide evidence of thorough investigations of all allegations of potential abuse for 2 of 4 residents (#9 & 10) for whom investigations had been completed. Not thoroughly investigating all allegations of potential abuse put residents at risk for further abuse, neglect or mistreatment. Findings include: 1. The facility's "Abuse of Patient - Allegations Involving Staff" policy, revision date 4/06, included the definition of neglect as "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The policy stated "The local area manager will be	F 225	*3.) What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur:* **Update Policy to reflect current State standards.** **Educate associates on changes to policy and procedures. Education will take place by providing a written copy of the new policy to all associates via the PPM (Policy Procedure Management System) electronically and have them read and sign off on understanding. All RNs and SAs will be educated.** **DON and ADON attended the Nurse Management Training for Skilled Nursing Facilities by the Idaho Health Care Association/Idaho Center for Assisted Living on March 19-21,2013. One module covered the investigation of potential abuse, neglect, and mistreatment of residents.** **Administrator or designee will investigate all incidents within 5 days of being notified and documentation will be entered into the Voice system (incident reporting system used at St. Alphonsus SNF).** *1.) How the corrective action will be monitored to ensure the deficient practice will not recur:* **A spreadsheet of any incidents that are investigated for potential abuse, neglect, or mistreatment will be maintained – Started on April 2, 2013**	

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F 225	Continued From page 2 charged with oversight of the full investigation and taking appropriate actions as indicated." However, patient records did not included documentation that thorough investigations had been conducted, as follows: a. An investigation documented on 12/11/12, Random Resident #10's family member "pushed the button to have a nurse come help her put [Random Resident #10] back to bed. Nobody answered the call for a while so I walked down to the nurses [sic] station, where 3 people looked at me and then continued on without even asking me if there was something they could help with. I finally went to the nurse closest and asked if someone could help. I told her that [Random Resident #10] wanted to go back to bed and she said that her nurse was in with another patient and would come down when she was done...by the time the nurse did finally come she was up for 50 minutes...she was at wits [sic] end and not feeling well..." The "Details" section of the investigation, completed by the Director of Nurses stated "Reviewed chart- complaints not brought to our attention when patient was here- without specifics there is not way [sic] for me to follow up with staff on concerns of waiting for assistance..." The investigation did not include documentation that an investigation or corrective action to prevent a future incident had occurred. During an interview on 3/8/13 from 10:45 - 11:35 a.m., the Director of Nurses stated no additional action was taken related to the incident.	F 225	• *Job title of who will do monitoring* **DON and ADON** • *Frequency of monitoring* **Twice a week X 1 month, then once a week X1 month** **Report results and any trends to SARMC SNF Quality committee for review and recommendation's from first month and then annually.** • *Start date of audits* **April 3, 2012**	

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F 225	Continued From page 3 b. An investigation, documented on 2/8/13, Random Resident #9 was found climbing out of his bed. The investigation stated staff "pulled the call light cord out of the wall, with no assistance arriving. This writer was able to transfer the patient into a wheelchair without incident, and then look out into the hallway for help. According to the nurse and others sitting at the nurses [sic] station, there was no alarm when the cord was pulled from the wall." The "Details' section of the investigation, completed by the Director of Nurses, stated the cord was tested and "worked just fine." The investigation did not include additional information (interviews with the staff at the nursing station at the time of the incident, assessment of how Random Resident #9 was able to get out of his bed, information related to how the call light was tested) or corrective action to prevent a future incident. During an interview on 3/8/13 from 10:45 - 11:35 a.m., the Director of Nurses stated no additional information related to the incident or how it was investigated existed. The facility failed to ensure all incidents of potential abuse, neglect, or mistreatment were thoroughly investigated.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F 226 *1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* **Residents #1- #10 no longer reside in the facility** *2.) How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken* **Review of current Incident Reports – completed on April 2, 2013** *3.) What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur*	4/12/13

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F 226	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of the facility's policies and procedures and staff interviews, it was determined the facility failed to ensure policies were adequately developed and implemented to monitor and track patterns of potential abuse, neglect, or mistreatment. This failure had the potential to impact any individual residing at the facility who sustained an injury of unknown origin or was subject to abuse, neglect, or mistreatment including 10 of 10 (#1 - 10) sample residents, and . This failure resulted in potential harm by not monitoring for patterns or trends of potential abuse, neglect, and mistreatment. Findings include: 1. The facility's "Abuse of Patient - Allegations Involving Staff" policy, revision date 4/06, and the facility's "Abuse, Exploitation or Neglect - Reporting of Vulnerable Adult" policy, dated 11/16/12, were reviewed. The policies did not include information related to trending and tracking patterns of potential abuse, neglect and mistreatment. During an interview on 3/8/13 from 10:45 - 11:35 a.m., the Director of Nurses stated formal processes to track and trend patterns of potential abuse, neglect and mistreatment had not been developed. The Director of Nurses stated stays at the facility were typically short enough that the entire record could be reviewed if there was concern of a pattern. The facility failed to ensure policies were	F 226	**Update Policy to include monitoring for trends and patterns of potential abuse, neglect, or mistreatment.** **Educate associates on policy changes and tracking of incidents for potential abuse, neglect, or mistreatment of residents. Education will take place by providing a written copy of the new policy to all associates via the PPM (Policy Procedure Management System) electronically and have them read and sign off on understanding. All RNs and SAs will be educated.** *4.) How the corrective action will be monitored to ensure the deficient practice will not recur* **A spreadsheet of any incidents that are investigated for potential abuse, neglect, or mistreatment will be maintained to monitor for trends or patterns – completed on April 2, 2013** • *Job title of who will do monitoring* **DON and ADON and MDS coordinator** • *Frequency of monitoring* **Twice a week X one month, then as new incident reports are submitted** **Report results and any trends to SARMC SNF Quality committee for review and recommendation's from first month and then annually.** *Start date of audits* **April 3, 2012**	

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F 226	Continued From page 5 sufficiently developed to include tracking and trending of patterns of potential abuse, neglect, and mistreatment.	F 226		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure medications were only administered when a clear indication of use and monitoring was present for 1	F 329	F 329 *1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* **Resident #5 no longer resides in the facility.** *2.) How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken* **Pharmacist and Medical Director to complete a review of medication of all resident records currently in the SNF – completed on April 2, 2013** *3.) What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur* **Write a policy on medication regime to reflect the standard "Drug regime is free from unnecessary drugs" (Paul Pomeroy).**	4/12/13

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F 329	Continued From page 6 of 6 residents (#5) whose medication regimens were reviewed. This resulted in a resident receiving a medication without an indicated use and the potential for the resident to experience significant side effects unnecessarily. Findings include: Resident #5 was admitted on 2/21/13 for decreased mobility and ADL skills as a result of a ground level fall with cervical fracture. Her 2/23/13 physician orders documented she was receiving Seroquel (an antipsychotic drug) 100 mg at bed time. Her record also contained an "Inpatient Patient Progress Note," dated 3/4/13. Item #6 on the note stated "Insomnia. She is on Seroquel." An additional "Inpatient Progress Note," dated 3/6/13, documented "Insomnia. She is stable on Seroquel." The 2013 Nursing Drug Handbook does not list insomnia as an indicated use for Seroquel. Additionally, the 2013 Nursing Drug Handbook documents the potential side effects of Seroquel to include neuroleptic malignant syndrome (a potentially life-threatening side effect) and tardive dyskinesia (an abnormal movement disorder). During an interview with the Director of Nurses on 3/8/13 from 8:15 - 8:37 a.m., she confirmed Resident #5 was receiving Seroquel for insomnia. The Director of Nurses stated Resident #5 had been on Seroquel prior to her admission and the physician had decided to continue it. The Director of Nurses also stated tardive dyskinesia ratings were not being completed for Resident #5.	F 329	**Pharmacist education to be completed by Paul Pomery.** **Physician and Physician Assistant education to be completed by Dr. Michael McMartin :** **Education will include that a medication review will occur on admission to the facility by the MD and any time a psychotropic medication regimen is changed, the MD will document the reasons for use of the psychotropic medications, and documentation will also include any concerns of adverse effects.** **Physician education will be completed.** *4.) How the corrective action will be monitored to ensure the deficient practice will not recur* **During the initial chart review the MDS coordinator will place any patients who are on psychotropic medications on a spreadsheet and verify physician review and documentation via a chart audit.** • *Job title of who will do monitoring* **MDS coordinator** • *Frequency of monitoring* **Upon completion of the 5 Day MDS X 1 month and then reevaluate for trends and compliance Report results and any trends to SARMC SNF Quality committee for review and recommendation's from**	

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F 329	Continued From page 7 The facility provided no other information regarding the use of drug.	F 329	**first month and then annually.**	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the pharmacist: - Completed a monthly medication review for a resident who had been at the facility for 33 days, and - Identified and reported a potentially serious medication irregularity. This was true for 2 of 6 sampled residents (#s 4 & 5) reviewed. This resulted in Resident #4 not having a monthly medication review and Resident #5 receiving an antipsychotic medication without an indication for use. Both deficient practices had the potential to cause harm to the residents if irregularities were not reported and responded to. Findings include: The guidance at Federal Regulation 441 related	F 428	**Report results and any trends to SARMC SNF Quality committee for review and recommendation's from first month and then annually.** • *Start date of audits* **Will start for all new residents admitted to the facility.** F 428 *1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* **Residents #4 and #5 no longer resides in the facility** *2.)How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken* **Chart review was completed on April 2, 2013 by the MDS coordinator and the DON and found no residents to be in the facility for equal to or greater than 30 days, no action needed.** *3.) What measures will be put in place or what systematic change you will make to ensure that the deficient practice does not recur* **Write a policy on medication regime to reflect the standard of F428 including the pharmacists role to be completed by Paul Pomeroy.**	4/12/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/201
FORM APPROVE
OMB NO. 0938-039

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F 428	Continued From page 8 to the Medication Regimen Review (MRR), documents, "The MRR is an important component of the overall management and monitoring of a resident's medication regimen. The pharmacist must review each resident's medication regimen at least once a month in order to identify irregularities; and to identify clinically significant risks and/or adverse consequences resulting from or associated with medications. It may be necessary for the pharmacist to conduct the MRR more frequently, for example weekly, depending on the resident's condition and the risks for adverse consequences related to current medications," and "During the MRR, the pharmacist applies his/her understanding of medications and related cautions, actions and interactions as well as current medication advisories and information. The pharmacist provides consultation to the facility and the attending physician(s) regarding the medication regimen and is an important member of the interdisciplinary team. Regulations prohibit the pharmacist from delegating the medication regimen reviews to ancillary staff." 1. Resident #4 was first admitted to the facility on 1/23/13, discharged to the hospital on 1/30/13, and readmitted to the facility on 2/2/13 with diagnoses including pneumonia, chronic airway obstruction, acute post-hemorrhagic anemia, chronic viral hepatitis C, essential hypertension, encephalitis, history of venous thrombosis and embolism, and non-traumatic hematoma right thigh. The resident's 14 day MDS assessment, dated 2/14/13, documented the resident was cognitively	F 428	Educate the pharmacists on the requirements and the policy: Paul Pomeroy. *4.) How the corrective action will be monitored to ensure the deficient practice will not recur* When completing the 30 day MDS the MDS coordinator will verify that the pharmacist has completed a medication regime review and has documented in the patient's record. A spreadsheet will be used to assure compliance. • *Job title of who will do monitoring* MDS coordinator • *Frequency of monitoring* With every 30 day MDS X 3 months Report results and any trends to SARMC SNF Quality committee for review and recommendation's from first month and then annually. • *Start date of audits* April 3, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135119	A. BUILDING _____ B. WING _____	03/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS TRU	1055 NORTH CURTIS ROAD BOISE, ID 83706

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F 428	Continued From page 9 intact with a BIMS of 15, had signs and symptoms of delirium, had no behavioral symptoms, and antipsychotic and antibiotic medications were administered 7 days per week. NOTE: The antipsychotic medication was discontinued on 2/19/13. The resident's current medications included Flagyl 500 mg by mouth four times per day (increased on 3/5/13 from twice per day), intravenous DAPTOmycin every 24 hours for a VRE infection, oxycodone for pain control, Combivent inhaler four times per day, and heparin therapy for anticoagulation effects. Although the resident's second admission to the facility occurred 33 days prior to the survey, no documentation of a MRR was found in the resident's chart. 2. Resident #5 was admitted on 2/21/13 for decreased mobility and ADL skills as a result of a ground level fall with cervical fracture. Her 2/23/13 physician orders documented she received Seroquel (an antipsychotic drug) 100 mg at bed time. The resident's 14 day MDS assessment, dated 3/5/13, documented the resident was cognitively intact with a BIMS of 15, had mild depression, had no hallucinations, delusions, or behavioral symptoms, and received an antipsychotic medication 7 days per week, antianxiety medications 5 days per week and antidepressant medications 7 days per week. Resident #5's record contained an "Inpatient Patient Progress Note," dated 3/4/13. Item #6 on the note stated "Insomnia. She is on Seroquel."	F 428		

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F 428	Continued From page 10 An additional "Inpatient Progress Note," dated 3/6/13, documented "Insomnia. She is stable on Seroquel." No documentation for tardive dyskenesia or other potentially serious side effects of the medication was found in the resident's record. The 2013 Nursing Drug Handbook (NDHB) lists indications for use of Seroquel as schizophrenia, short term treatment of acute manic episodes associated with bipolar disorder, depression associated with bipolar disorder, major depression disorder and obsessive -compulsive disorder. Insomnia was not listed as an indicated use for Seroquel. In addition, the the 2013 NDHB documented, "Monitor patient for tardive dyskinesia... which may occur after prolonged use... Watch for evidence of neuroleptic malignant syndrome (extrapyramidal effects, hypothermia, autonomic disturbance) which is rare but deadly." The pharmacist failed to identify and report the lack of an appropriate indicated use for the Seroquel or a justification for the off label use. The pharmacist also failed to note that the facility was not monitoring for tardive dyskinesia or other potential side effects of the Seroquel. On 3/7/13 at 2:00 pm, the Pharmacy Manager (PM) for the Transition Rehabilitation Unit (unit) stated that resident medications were reviewed and a medication reconciliation report was completed on the day residents were transferred to the unit from the hospital floor. Other than doing the medication reconciliation at the time of transfer, the PM stated the pharmacists did not routinely review the residents' medications, this	F 428		

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F 428	Continued From page 11 was left up to the "MD" (physician) who saw the resident daily. When asked if the pharmacy did a MRR for those residents who were at the facility for more than a month, or for other medication irregularities that could potentially have adverse consequences, the PM stated, 'No, we did not know we needed to." During an interview with the Director of Nurses (DON) on 3/8/13 from 8:15 - 8:37 a.m., she confirmed Resident #5 was receiving Seroquel for insomnia. The DON stated Resident #5 had been on Seroquel prior to her admission and the physician had decided to continue it. The DON also stated tardive dyskinesia ratings had not been completed for Resident #5. On 3/8/13 at 4:15 pm the Administrator and DON were notified of the unresolved issues regarding MRRs. The facility provided no additional documentation or information that resolved the concerns.	F 428		

Bureau of Facility Standards

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	MDS001680	A. BUILDING: _____ B. WING _____	03/08/2013

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the state licensure survey of your facility. The surveyors conducting the survey were: Lorraine Hutton, RN, Team Coordinator Jim Troutfetter, MEd, QMRP Michael Case, BSW, LSW, QMRP Monica Nielsen, MEd, QMRP Trish O'Hara, RN	C 000	RECEIVED APR 05 2013 FACILITY STANDARDS	
C 107	02.100,02,b Written Policies/Procedures b. The administrator shall be responsible for establishing and assuring the implementation of written policies and procedures for each service offered by the facility, or through arrangements with an outside service and of the operation of its physical plant. The policies and procedures shall further clearly set out any instructions or conditions imposed as a result of religious beliefs of the owner or administrator. The administrator shall see that these policies and procedures are adhered to and shall make them available to authorized representatives of the Department. If a service is provided through arrangements with an outside agency or consultant, a written contract or agreement shall be established outlining the expectations	C 107	See F 225 and F 226.	

Bureau of Facility Standards

Pascale Sweetgrass — TITLE DON — (X6) DATE 4/3/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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C 107	Continued From page 1 of both parties. This Rule is not met as evidenced by: Refer to F225 and F226 as it relates to a lack of investigation and accidents and policy development.	C 107		
C 147	02.100,05,g Prohibited Uses of Chemical Restraints g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Refer to F329 as it relates to Seroquel being used to treat insomnia.	C 147	See F 329.	
C 175	02.100,12,f Immediate Investigation of Incident/Injury f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F226 as it relates to a lack of thorough investigations.	C 175	See F 226.	
C 820	02.201,01,a a. Reviewing the medication profile for each individual patient at least	C 820	See F428.	

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C 820	Continued From page 2 every thirty (30) days. The attending physician shall be advised of drug therapy duplication, incompatibilities or contraindications. This Rule is not met as evidenced by: Refer to F428 as it relates to the medication irregularities being identified and reported.	C 820		